Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BURDIN CHIROPRACTIC NEUROLOGY & REHAB CLINIC
9502 COMPUTER DR SUITE #200
SAN ANTONIO TX 78229

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
CITY OF SAN ANTONIO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-7898-01

MFDR Date Received
APRIL 23, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "As the treating doctor, Dr. Brad Burdin felt it medically necessary to bring in [injured worker] because she was responding positivly [sic] to treatment. According to the Division of Workers Comp. rules, the provider is not required to request preauthorization within the first two weeks of the DOI. This date of service falls seven days after the patient reported the injury. According to this rule, the carrier is obligated to pay for services rendered during the first two weeks without pre-authorization. We were denied payment on July 10, 2008 due to the absence of pre-auth. or pre-cert. and again on March 27, 2009 for the same reason. Our office is now seeking reimbursement through the assistance of the Division of Workers Compensation."

Amount in Dispute: $209.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Respondent has previously issued payment on this matter…Respondent's EOB reflecting this payment is attached."

Response Submitted by: Harris & Harris, PO Box 71569, Austin, TX 78709

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2008	Chiropractic treatment and physical threapy	$209.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement for professional services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1A – Workers Compensation State Fee Schedule Adjustment
   - 197A – Precertification/authorization/notification absent. Pre-Authorization required under rule 134.600, but provider did not request.

Issues

1. Was the requestor reimbursed for the treatment provided to the claimant?
2. Is the requestor entitled to reimbursement?

Findings

1. Review of the disputed date of service finds that the respondent submitted EOBs showing payment was made to the requestor in accordance with 28 Texas Administrative Code §134.203(b)(2)(c).
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) has been made to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 1, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.